

1436

11428

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <i>Mary</i>	Middle <i>Armstrong</i>	Last	2a. DATE OF DEATH Month <i>8</i> Day <i>29</i> Year <i>68</i>		2b. HOUR <i>6:00 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		S. DATE OF BIRTH <i>06-25-97</i>	6. AGE (In years last birthday) <i>71</i> YRS.		1e UNDER 1 YEAR MONTHS <i>0</i> DAYS HOURS <i>0</i> MIN	
7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i>				
10. CITY OR TOWN OF DEATH <i>Rural Cambridge</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>UNKNOWN - Retired.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Caroline Ridgely.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>NONE</i>		
14. FATHER'S NAME First <i>Ernest</i> Middle <i>Armstrong</i> Last <i>4100</i>		15. MOTHER'S MAIDEN NAME First <i>Julia</i> Middle <i>Wilkinson</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>92-07-4481</i>		17. INFORMANT <i>Med. Records</i> , Address <i>Eastern Shore State Hospital</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 HOUR.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>		DUE TO, OR AS A CONSEQUENCE OF (c)		SEVERAL YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>MAY 6, 1968</i> , to <i>AUG 29, 1968</i> , that (I) (we) last saw the deceased alive on <i>AUG. 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Miguel A. de la Guardia, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED <i>8/29/68</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>E.S.S. 4.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-2-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Union</i>		23d. LOCATION (City or Town) <i>Goldsboro, Md.</i>		(County) <i>Gold</i>	(State) <i>North Carolina</i>
24. FUNERAL DIRECTOR <i>J. E. Boulaire</i>		ADDRESS <i>Goldsboro, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 3 may be removed by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

12
FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

11429 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 1, 2, and 3 to be filed in Item 18

11437

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	24. HOUR P.M.
Reginald E. Gilbert Bailey Jr. Sr.				8/ 27 1968 11:00				
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN	2d. HOUR P.M.
Male	Negro	5/3/1938	30 YRS					11:00
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
Md.	USA		Dorchester					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge	527 Cedar St.	Barber						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER					
Md.	Dorchester	Cambridge	527 Cedar St.					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Russell	Reginald	E.	Bailey Jr.	Blanche	Elizabeth	Jackson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (Type, give war or dates of service)	17. INFORMANT	ADDRESS					
Yes	Korean	218-34-8066	Gloria Bailey 527 Cedar St. Camb. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand mal Epilepsy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3531								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 9/4/68		
EXAMINER'S NAME (Type) John Mace Jr. M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/1/68	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	23d. LOCATION (City or Town) Cambridge, Dor. Md.	(County)	(State)		
24. FUNERAL DIRECTOR St. Clair Funeral Est.		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR SEP 9 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with ~~Item 3~~ PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the ~~3rd~~ Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11438

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month OF ESTI- MATED <input type="checkbox"/> Day 8 7 Year 1968	2b. HOUR 35 M
Charles	F.	BANNING					
3. SEX MALE	4. RACE white	5. DATE OF BIRTH 10-06-75	6. AGE (In years lost birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF HOURS 0	IF MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester	2c. DATE PRONONCED DEAD Month 8	Day 7	Year 1968	2d. HOUR 2:35 A.M.
10. CITY OR TOWN OF DEATH Cambridge (Fulton)	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter, Carpenter, Carpenter	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN EASTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route #1, Box 105			
14. FATHER'S NAME James	First A	Middle BANNING	15. MOTHER'S MAIDEN NAME Tyler, MARY ANN BANNING				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Not listed	17. INFORMANT Eastern Shore State Hosp. Cambridge, MD	ADDRESS (Med Records)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>terminal pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF 887X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prosthetic heart</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9047				3 days.			
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7 AM 8/14/1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fall in hospital				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital	21f. LOCATION Street or R.F.D. No. City or Town County State	Carrying, Md. 20701				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				22b. DATE SIGNED 8/17/68			
ACTUAL SIGNATURE JOHN MACE JR.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JOHN MACE JR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/19/1968	23c. NAME OF CEMETERY OR CREMATORIAL SPRING HILL	23d. LOCATION (City or Town) (County) (State) EASTON, MD				
24. FUNERAL DIRECTOR Maurice E. Neustadt, Jr.	ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				

卷之三

January 7 1914

2028-20-01 04:00:00

Went to see the 1925 and 1926 collections (part) yesterday.

Exhibit 15 shows x noted today dual game

and in 1948 23% found a seat

6 hours of static and active rotation

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11431

11439

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First WILLIAM	Middle CATHROP	Lost CHAMBERS	2a. DATE OF DEATH Month 8	Day 17	Year 68	2b. HOUR 7:25 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 4, 1894		6. AGE (In years lost birthday) 74		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland UNKNOWN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13c. CITY OR TOWN CAROLINE PRESTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #2			
14. FATHER'S NAME First BASCOM		Middle NICHOLSON	Last CHAMBERS	15. MOTHER'S MAIDEN NAME First MARY		Middle IDA	Last TODD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 212-56-1195		17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 Bronchopneumonia		DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. RT. side		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause undeter.		DUE TO, OR AS A CONSEQUENCE OF, (c) Generalized atherosclerosis		undeter.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X Chronic pyelonephritis.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 8/10/1968 to 8/17/1968 , that (I) (we) lost saw the deceased alive on 8/17/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Faruk Ozer		DEGREE ATTENDING PHYS.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8/17/68			
22d. PHYSICIAN'S NAME (Type) FARUK OZER		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Reburial		23b. DATE Aug. 21, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Junior Order Cemetery		23d. LOCATION (City or Town) Preston, Maryland		(County)	(State)
24. FUNERAL DIRECTOR James Brumpton, Jr. Federalsburg, Maryland		ADDRESS		25a. REC'D. BY REGISTRAR DATA AUG 22 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge			

FOR STATE
HEALTH DEPT.

1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

2 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11440

1. DECEASED-NAME (Type or Print)	First John	Middle Wesley	Last Chester	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 8	Day 30	Year 1968	2b. HOUR 11:44 P.M.					
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 2/12/6909	6. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month 8	Day 30	Year 1968	2d. HOUR 11:44 P.M.		
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester									
10. CITY OR TOWN OF DEATH Church Creek	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St.Rt. 335			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Church Creek	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/>	13e. STREET AND NUMBER No. 0										
14. FATHER'S NAME Robert James Chester	15. MOTHER'S MAIDEN NAME Nettie Keene												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 216-07-3152	17. INFORMANT Edmund Chester	ADDRESS Church Creek, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries, severe</u> DUE TO, OR AS A CONSEQUENCE OF 814.7 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 812.4													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:30 A.M. PM 8/30/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Was hit by a car.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. St. Rt. 335 nr. Church Creek, Dor. Md.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Mace Jr.</i>		22b. DATE SIGNED 9/4/68											
EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/3/68	23c. NAME OF CEMETERY OR CREMATORIAL Old Field Cemetery	23d. LOCATION (City or Town) Church Creek, Dor. Md.	(County)	(State)								
24. FUNERAL DIRECTOR St. Clair Funeral Est. Cambridge, Md.	ADDRESS	25a. REC'D BY REGISTRAR SEP 9 1968	25b. REGISTRAR SIGNATURE <i>Charles Judge</i>										

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11461

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First NELLIE	Middle W.	Last CHRISTOPHER	2a. DATE OF DEATH Month Aug. 24 1968	2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 7, 1886		6. AGE (In years last birthday) 82	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Dorchester	IF UNDER 24 HRS. HOURS MIN.
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School Teacher-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Teaching	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 212 Maryland Avenue	
14. FATHER'S NAME Thomas	First Middle ?	Last Christopher	15. MOTHER'S MAIDEN NAME Fannie	Middle ?	Last Tuttle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. - - -	17. INFORMANT LeCompte Funeral Service records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 10 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>4201</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>8/13/68</i> , 19, to <i>8/24/68</i> , 19, that (I) (we) last saw the deceased alive on <i>8/24/68</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Lawrence Marjanov</i>	22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED <i>8/26/68</i>		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>610 Race St Cambridge, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 27, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland	ADDRESS LeCompte Funeral Service, Cambridge, Maryland	25a. REC'D BY REGISTRAR DATE AUG 28 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1. *U. S. Fish Commission, 1881-1882* (1884)

Glossary

"Food for Thought?"

FOR STATE
HEALTH DEPT.

W is
of

any delay
es 1, 2, and
form PMJ.

18. Give four along with 2 with me at death.

within 24 hours
pencil in Item
Examiner's Office
file pages 1 and
72 hours after

ertificate should be executed
ing the word "pending" in
rder to the Chief Medical E
os a burial-transit permit. F
al, and in any event within

inner
e cer
shou
files.
3 sho
ation

KAMIE
the
e 4
our
page
trem

Ex-
ecut-
ive
for
Y
OR: P
rial, a

ICA
se ex-
ector.
med
ECTC
e bur

DIR
or to

ary,
neral
be
ERAL
pri

DEP
FUND
MOY
E FUN
CESS

10 ne
th 5 10 He

VR A15ME (5)
10M REV. 1/68

JOM REV. 1/66

11434

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11442

1. DECEASED-NAME (Type or Print)		First	Middle	Lost		20. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR	
Helen Josephine Conaway						8/22		68		10:30	
3. SEX Female	4. RACE Negro	S. DATE OF BIRTH 1/7/1923	6. AGE (In years last birthday) 45	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 8 Day 22 Year 68			2d. HOUR 10:30
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester				Mo	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 414 Charles St.					
14. FATHER'S NAME James		Middle E. Chester	Lost	15. MOTHER'S MAIDEN NAME Viola		First E. Conaway	Middle	Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 215-16-3641		17. INFORMANT Viola Rhodes		414 ADDRESS Charles St. Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) XXXXXX XXXX XXXX XXXX Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Following GYN surgery										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 214X											
19a. DATE OF OPERATION 8/22/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Leiomyomata uteri				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED 9/4/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/25/68	23c. NAME OF CEMETERY OR CREMATORIAL Cordtowm Cemetery		23d. LOCATION (City or Town) Cambridge, Dor. Md.		(County)	(State)			
24. FUNERAL DIRECTOR St. Clair Funeral Est.		ADDRESS Cambridge, Md.		25a. RECD BY REGISTRAR DATE SEP 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

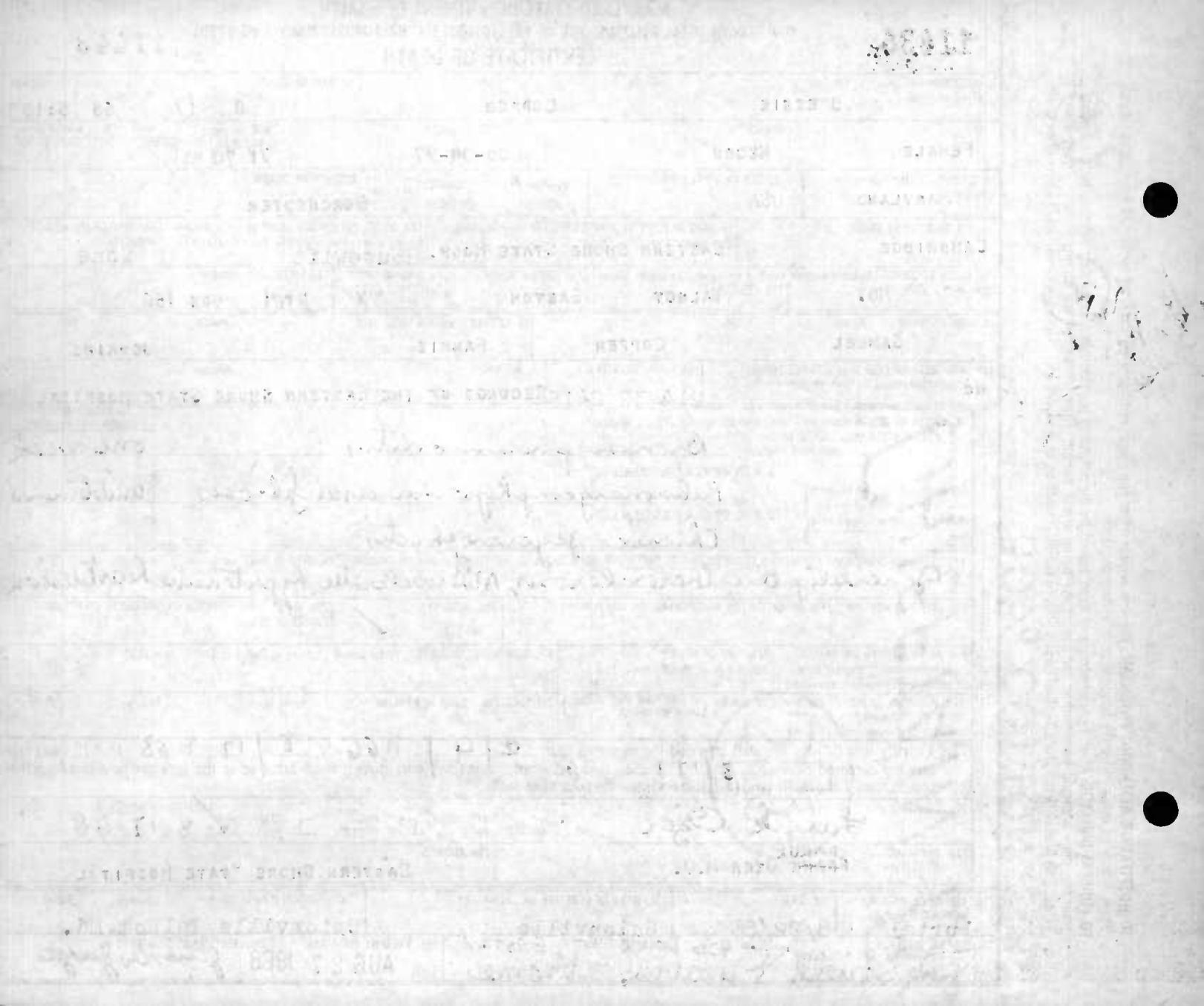
11435

11443

CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First B ESSIE	Middle	Lost COPPER	2a. DATE OF DEATH Month 8 Day 17 Year 68	2b. HOUR P 5:10
3. SEX FEMALE	4. RACE NEGRO	5. DATE OF BIRTH 09-04-97	6. AGE (In years last birthday) 71 70 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER		
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY TALBOT	13c. CITY OR TOWN EASTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT#1 Box 156	Md.
14. FATHER'S NAME First SAMUEL	Middle COPPER	15. MOTHER'S MAIDEN NAME First FANNIE	Middle Last JENKINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO no, or unknown	16b. SOCIAL SECURITY NO. 214 32 2415	17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5271 (b) Pulmonary emphysema and fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic pyelonephritis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized atherosclerosis, Atherosclerosis, hypertensive heart disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 2/4/66 to 8/17/68 , that (I) (we) last saw the deceased alive on 8/17/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frank Ozer	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8.17.68	
22d. PHYSICIAN'S NAME (Type) FRANK OZER M.D.	22e. ADDRESS EASTERN SHORE STATE HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/22/68	23c. NAME OF CEMETERY OR CREMATORIUM Unionville	23d. LOCATION (City or Town) Unionville	(County) Talbot	(State) Md.
24. FUNERAL DIRECTOR Charles Judge	426 Douglass Street ADDRESS Dashiel Funeral Home	EASTON	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE AUG 27 1968



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR			
LOUISE			DAVIS	COSTON		AUGUST	28	1968	8:00PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS	
FEMALE		NEGROID		APRIL 6, 1906			62 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
VIRGINIA		USA					DORCHESTER					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
CAMBRIDGE		423 CHARLES STREET			LABORER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
MARYLAND		DORCHESTER		CAMBRIDGE		YES <input checked="" type="checkbox"/>		423 CHARLES STREET				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
		CALVIN	DAVIS		JANET				DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address					
NO				JANET LAND			423 CHARLES ST.				21613	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
4129												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary heart disease												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4201		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
19c. MEDICAL CERTIFICATION												
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.			City or Town		County State			
22a. I certify that (I) (this hospital attended the deceased from Sept. 26, 1967 , to August 28, 1968 , that (I) (we) last saw the deceased alive on August 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>John E. Fasett</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED Aug. 31, 1968						
22d. PHYSICIAN'S NAME (Type)		J. EWIN FASSETT, M.D.		22e. ADDRESS 823 HIGH STREET, CAMB., MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9/26/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CALVERT			23d. LOCATION (City or Town) NORFOLK		(County) (State) VIR.			
REMBURIAL												
24. FUNERAL DIRECTOR <i>John E. Fasett</i>		ST. CLAIR FUNERAL H. CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DA SEP 9 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

not having had any
experience in
the field.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11438

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11445

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First ANNA	Middle KATHRYN	Last KATHRYN CUNNINGHAM	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>			Month Aug	Day 30	Year 1968	2b. HOUR M	
3. SEX Female	4. RACE White	S. DATE OF BIRTH Nov 8 1916	6. AGE (in years last birthday) 51	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month 0			Day 19	Year M	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester			Md.	
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 315 Newburg Avenue				
14. FATHER'S NAME First Aloysius			Middle Kaylor	Last	15. MOTHER'S MAIDEN NAME First Ann			Middle	Last	Sponski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-36-2474			17. INFORMANT Mr. Regis Cunningham, Catonsville, Md.			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoglycemia DUE TO, OR AS A CONSEQUENCE OF Overdose insulin (b) Overdose insulin DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 270x Coronary heart disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr.													
22b. DATE SIGNED 8/30/68													
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial			23b. DATE 9-4-68	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem.			23d. LOCATION (City or Town) (County) (State) Woodlawn Md						
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland			ADDRESS			25a. REC'D BY REGISTRAR SEP 5 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

PROBLEMS IN THE FIELD OF AGRICULTURE

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

10

1961

1961

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11446

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Lyda	Middle Evelyn	Last Dean	2a. DATE OF DEATH Month August	Year 1968	2b. HOUR 230 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 7, 1891		6. AGE (In years last birthday) 77	YRS.	IE UNDER 1 YEAR MONTHS DAYS	IE UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk	12b. KIND OF BUSINESS OR INDUSTRY Department store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 301 West End Ave.				
14. FATHER'S NAME W.	First Thomas	Middle Andrews	Last Kate	15. MOTHER'S MAIDEN NAME Stewart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 211-07-7208	17. INFORMANT Mrs. Earl Bennett	Address Cambridge Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 62 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332 X								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 6/13, 1968, to 8/7, 1968, that (I) (we) last saw the deceased alive on 8/7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED 8/8/68	
22b. SIGNATURE J. Gunby Jr MD	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.					
22d. PHYSICIAN'S NAME (Type) W. E. GUNBY JR. M.D.	22e. ADDRESS CAMBRIDGE MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 9, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	23d. LOCATION (City or Town) Cambridge	(County) Dorchester	(State) Md.			
24. FUNERAL DIRECTOR Kerrnett R. Thorpe Jr.	ADDRESS Cambridge Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE DATE AUG 14 1968					

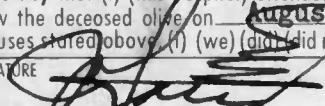
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

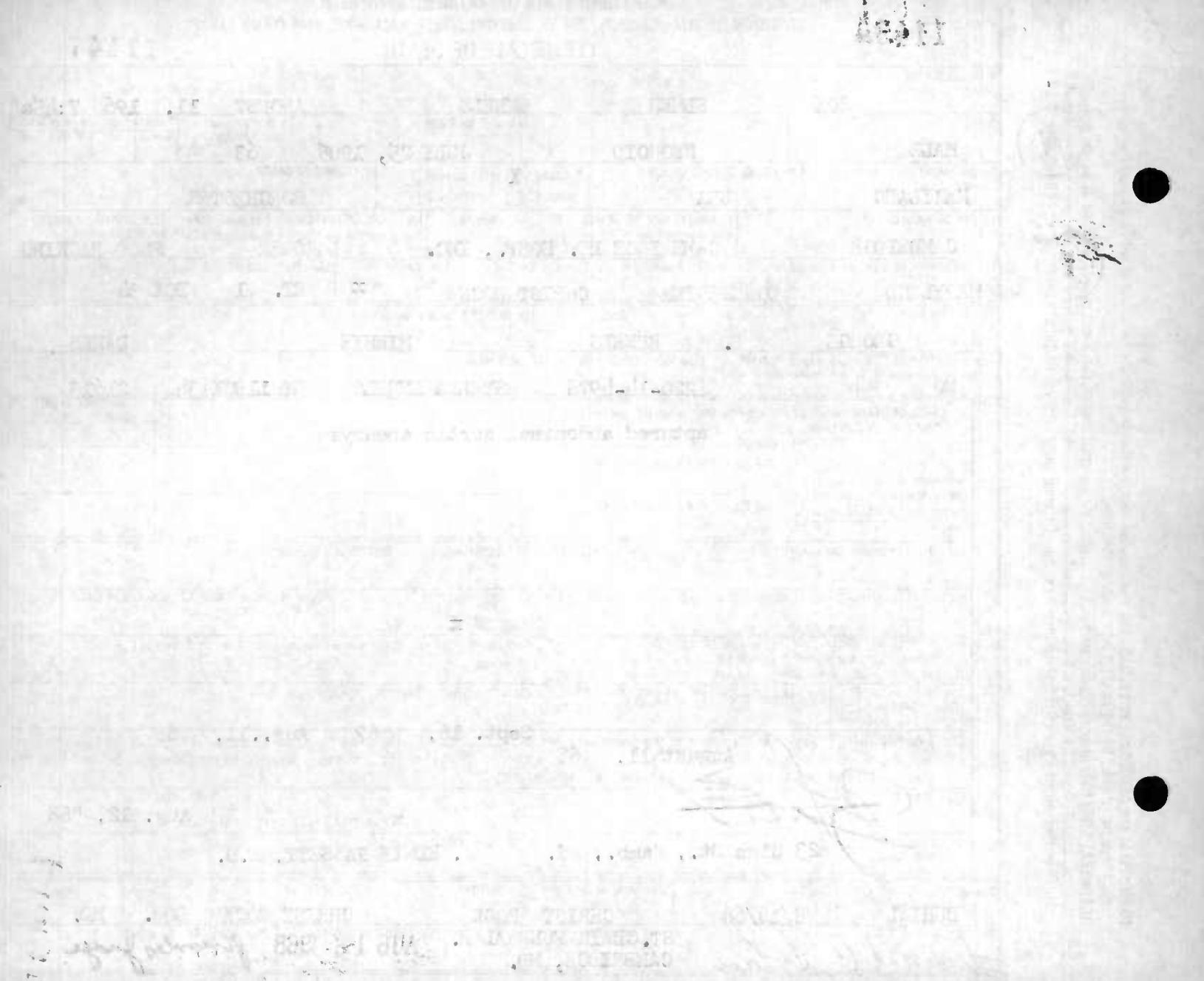
CERTIFICATE OF DEATH

11447

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the seal or paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)	First ROY	Middle ELMER	Last ENNELS	2a. DATE OF DEATH Month AUGUST	Day 11	Year 1968	2b. HOUR 7:15a M
3. SEX MALE	4. RACE NEGROID	5. DATE OF BIRTH JULY 25, 1905		6. AGE (In years last birthday) 63		7. IF UNDER 1 YEAR MONTHS 0	
8. MARRIED WIDOWED		9. COUNTY OF DEATH DORCHESTER		8. MARRIED NEVER MARRIED WIDOWED		9. COUNTY OF DEATH DORCHESTER	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MD. HOSP., INC.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER	
10. CITY OR TOWN OF DEATH CAMBRIDGE		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13c. CITY OR TOWN CHRIST ROCK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME GEORGE		First P.	Middle ENNELS	15. MOTHER'S MAIDEN NAME First MINNIE		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 220-11-1978		17. INFORMANT ESTELLA ENNELS		Address RT 11 BOX 34	12b. KIND OF BUSINESS OR INDUSTRY FOOD PACKING
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 441.2							
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 451X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 16, 1967</u> , to <u>Aug. 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>Aug. 12, '68</u>	
22d. PHYSICIAN NAME (Type)		22e. ADDRESS <u>623 High St., Camb., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8/14/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL CHRIST ROCK		23d. LOCATION (City or Town) (County) (State) CHRIST ROCK DOR. MD.	
24. FUNERAL DIRECTOR <u>Federick C. Delair</u>		25a. REGD. BY REGISTRAR ST. CATHARINE FUNERAL H. CAMBRIDGE, MD.		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>		DATE <u>AUG 16 1968</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH 8 Month 16 Day 1968	2b. HOUR
CLEOPHUS FREDERICK ESKRIDGE							
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JULY 14, 1901			6. AGE (in years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH DORCHESTER		
10. CITY OR TOWN OF DEATH BALESTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving street address) RFDS SEAFORD, DEL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ARTIFER			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN BALESTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFDS SEAFORD, DEL			
14. FATHER'S NAME ARTHUR DESKRIDGE	First	Middle	Last	15. MOTHER'S MAIDEN NAME FLORENCE WHEATLEY	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown	16b. SOCIAL SECURITY NO. 821-10-9514			17. INFORMANT HAROLD F. ESKRIDGE, RFDS SEAFORD, DEL	Address BALESTOWN		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Carcinoma Lung							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma bladder							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
1810							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Octomy, 1966 , to Aug, 1968 , that (I) (we) last saw the deceased alive on Aug, 1966 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John T. Bulkeley, M.D.							
22d. PHYSICIAN'S NAME (Type)		22e. DEGREE M.D.		ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8-20-68
22f. ADDRESS Pine Bluff Rd, S. Salisbury, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 8/19/1968	23c. NAME OF CEMETERY OR CREMATORIAL FIREMEN'S		23d. LOCATION (City or Town) SHARPTONIX, MD	(County)	(State)
24. FUNERAL DIRECTOR NEWNAM FUNERAL HOME, SHARPTONIX, MD		ADDRESS		25a. REC'D. BY REGISTRAR DATE AUG 23 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

9412

8-1-2008

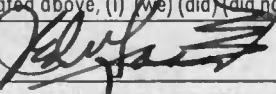
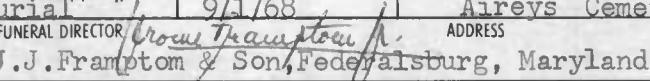
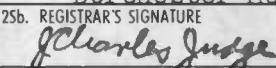
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11449

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Raymond	Middle	Lost Fisher	2a. DATE OF DEATH Month August	Day 29	Year 1968	2b. HOUR 4 p. m.	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH April 4, 1886		6. AGE (In years lost birthday) 82 yrs.		7. IE UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Day Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland R.F.D. 2	13b. COUNTY Dorchester	13c. CITY OR TOWN Vienna	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER				
14. FATHER'S NAME Peter	First A	Middle Fisher	Last	15. MOTHER'S MAIDEN NAME Elizabeth	Middle A.	Lost Carr		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 214-36-5169	17. INFORMANT Mrs. Lettie M. Young-East New Market, Md. R.F.B.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to urinary retention</u> DUE TO, OR AS A CONSEQUENCE OF Prostatic hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 600 X (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic cardiovascular renal disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 10, 1967</u> , to <u>August 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>Sept. 5, 1968</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>823 HIGH STREET, CAMBRIDGE, MD. 21613</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/1/68	23c. NAME OF CEMETERY OR CREMATORIAL Aireys Cemetery		23d. LOCATION (City or Town) Vienna	(County) Dorchester	(State) Md.		
24. FUNERAL DIRECTOR 	ADDRESS J. J. Frampton & Son, Federalsburg, Maryland	25a. REC'D BY REGISTRAR DAT SEP 9 1968		25b. REGISTRAR'S SIGNATURE 				

6222 RECENT EVIDENCE FROM THE MOUNTAIN
1430 10 MAY 1942

132

43701 10 MAY 1942 - 80

notched - pointed - not sharp

fragile - sharp

sharp - fine - very sharp - very sharp - pointed

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

11442

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11450

1. DECEASED-NAME (Type or print)	First Dora	Middle Jeanette	Last Gallagher	2a. DATE OF DEATH Month Aug	Day 24	Year 1968	2b. HOUR 9 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Nov. 23, 1879		6. AGE (In years last birthday) 88	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Dorchester	Md.				
10. CITY OR TOWN OF DEATH Rhodesdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Dorchester	13c. CITY OR TOWN Rhodes- dale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rural				
14. FATHER'S NAME First Eugene	Middle --	Last Coulbourn	15. MOTHER'S MAIDEN NAME First Linda	Middle --	Last Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-36-1031	17. INFORMANT Mrs. Charles Hurlock, Rhodesdale, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis 12 hr. 5 yr. 20 yrs.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from November 6, 1961 , to June 19, 1968 , that (I) (we) last saw the deceased alive on June 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE W. Trapnell		22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8-27-68			
22d. PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D.		22e. ADDRESS Federalsburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cem.	23d. LOCATION (City or Town) Federalsburg, Car. Md.	(County) 	(State) 			
24. FUNERAL DIRECTOR W. Trapnell & Son, Federalsburg, Maryland	ADDRESS	25a. REC'D BY REGISTRAR 		25b. REGISTRAR'S SIGNATURE Charles Judge				
		DATE AUG 30 1968						

卷之三

ANSWERED QUESTIONS

1704

89-0581-03-10

卷之三

• Lamp

2000-2001

四

中華書局影印

卷之三

110

22022-2022

1504

eJahagni

2021-03-26 2021-03-26 00:00:00

- 6 -

2000

卷之三

Appendix 3

卷之三

20

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11451

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First ERNEST	Middle L.	Last GILBERT, Sr.	2a. DATE OF DEATH Month Aug. 25	2b. HOUR Year 1968
3. SEX Male		4. RACE White		S. DATE OF BIRTH Dec. 21, 1911	6. AGE (In years last birthday) 56	IF UNDER 1 YEAR MONTHS YRS.
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
9. COUNTY OF DEATH Dorchester						Md.
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tool & Die Maker		12b. KIND OF BUSINESS OR INDUSTRY Electronics
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Dorchester		13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1102 Glover Street
14. FATHER'S NAME First Nathan		Middle C.	Last Gilbert	15. MOTHER'S MAIDEN NAME First Clara	Middle ?	Last Todd
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Unk		16b. SOCIAL SECURITY NO.		17. INFORMANT LeCompte Funeral Service records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109		DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Coronary occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
(b) DUE TO, OR AS A CONSEQUENCE OF		(c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
State						
22a. I certify that (I) (this hospital) attended the deceased from 8/22/68, 19, to 8/25/68, 19, that (I) (we) last saw the deceased alive on 8/23/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Lawrence Maryanov MD		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/26/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 610 Race St Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 28, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery		23d. LOCATION (City or Town) (County) (State) Smyrna, Delaware
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles J. Jones
				DATE AUG 28 1968		

15/11/88

8207

1981-8-20

1981-8-20

1981-8-20

1981-8-20

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

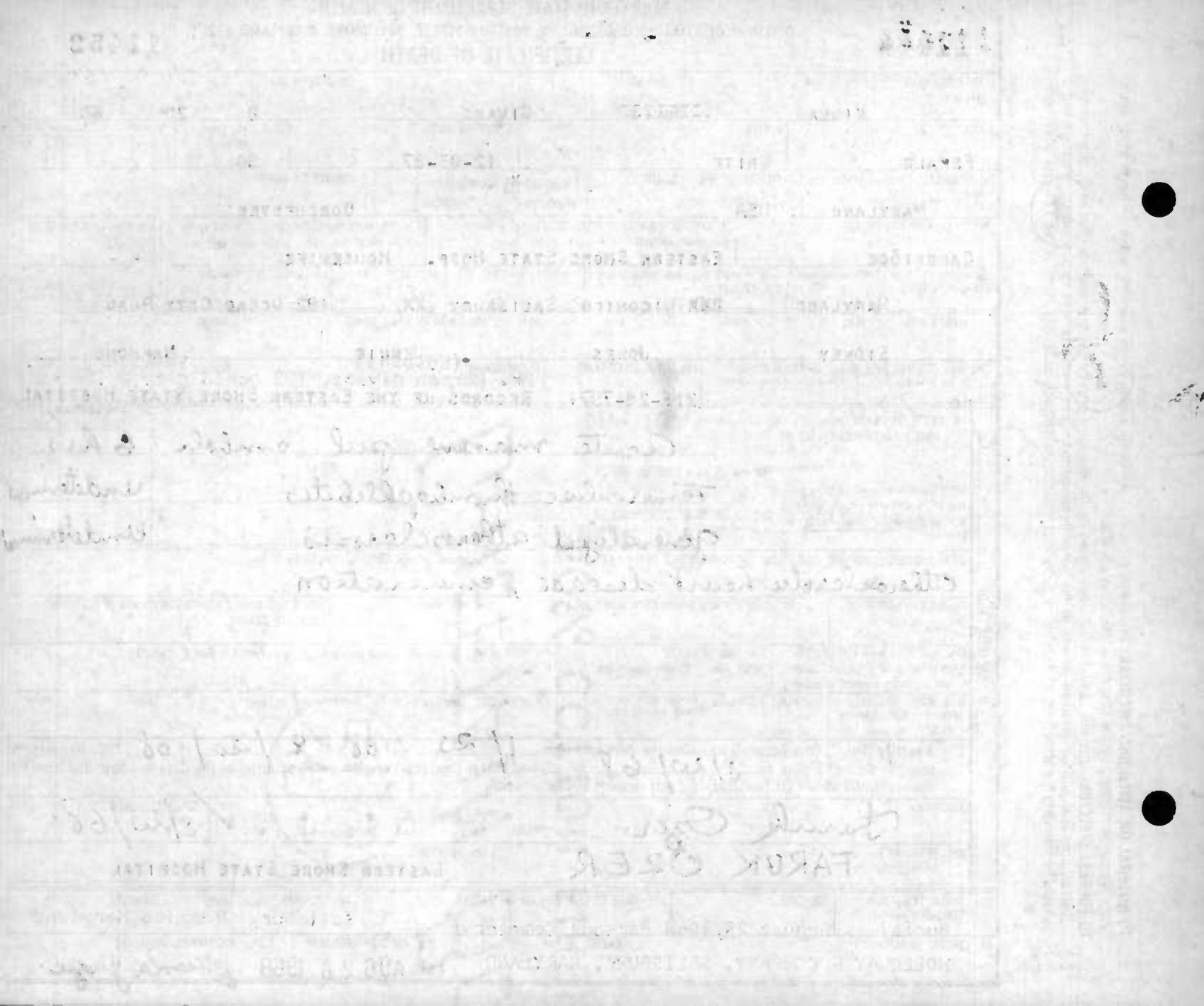
CERTIFICATE OF DEATH

11452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

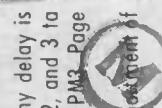
1. DECEASED-NAME (Type or print)	First VIOLA	Middle — COLES	Last GIVANS	20. DATE OF DEATH Month 8	Day 20	Year 68	2b. HOUR M					
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 12-03-87			6. AGE (In years lost birthday) 80	YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	MIN 0		
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER								
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY —					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WICOMICO	13c. CITY OR TOWN SALISBURY	13d. INSIDE CITY LIMITS? XX	13e. STREET AND NUMBER 192 OCEAN CITY ROAD								
14. FATHER'S NAME First SIDNEY	Middle JONES	Last JENNIE	15. MOTHER'S MAIDEN NAME First HAMMOND	Middle SALISBURY, Md.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 214-28-7971	17. INFORMANT (Husband) Mr. Herman Givans, 192 Ocean City Rd. RECORDS OF THE EASTERN SHORE STATE HOSPITAL			Address 192 OCEAN CITY ROAD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Acute massive pul. emboli. 6 hrs. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4500 Femoralis thrombophlebitis Undetermined (b) Generalized atherosclerosis Undetermined												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1(o) Atherosclerotic heart disease, emaciation.												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from 11/23/68 to 8/20/68 , that (I) (we) last saw the deceased alive on 8/10/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Faruk Ozer</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/20/68								
22d. PHYSICIAN'S NAME (Type) FARUK OZER.	22e. ADDRESS EASTERN SHORE STATE HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 23, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery			23d. LOCATION (City or Town) Salisbury, Wicomico, Maryland		(County) Salisbury, Wicomico, Maryland		(State)			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND	ADDRESS			25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge						



MISSOURI STATE HIGHWAY

43565

1
FOR STATE
HEALTH DEPT.



1
11445
Items 14 & 15
14. BURIAL, CREMATION, REMOVAL (Specify) 15. DATE
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
11445
11453

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	20. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR	
<i>Hubert Cooper Harper</i>						<input type="checkbox"/>	8	1	1968	8P M	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male	White	01-30-92	76 yrs.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD			
Md.		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Month	Day	Year	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Rural-Cambridge		Shore State Hosp									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.		Dor.		Nurlock	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John James A. Harper						Mary Wright Harper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
GUNNAR J. SWI			51123-600			Med. Records			1 week		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DUE TO, OR AS A CONSEQUENCE OF			20. DUE TO, OR AS A CONSEQUENCE OF			4 weeks		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Terminal Oncosis								
889X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF					
(b)			Infection with tumor								
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9047			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
19c. MEDICAL CERTIFICATION									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
Hospital						R.F.D. Cambridge			Co. Dor. Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>8/2/68</i>		
			JOHN MACE JR.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town) (County) (State)		
Burial			8/5/68			Washington			Burlock Dor. Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John S. Bellomy, East New Market									Charles George		
DP						DATE AUG 8 1968					

2300 231A

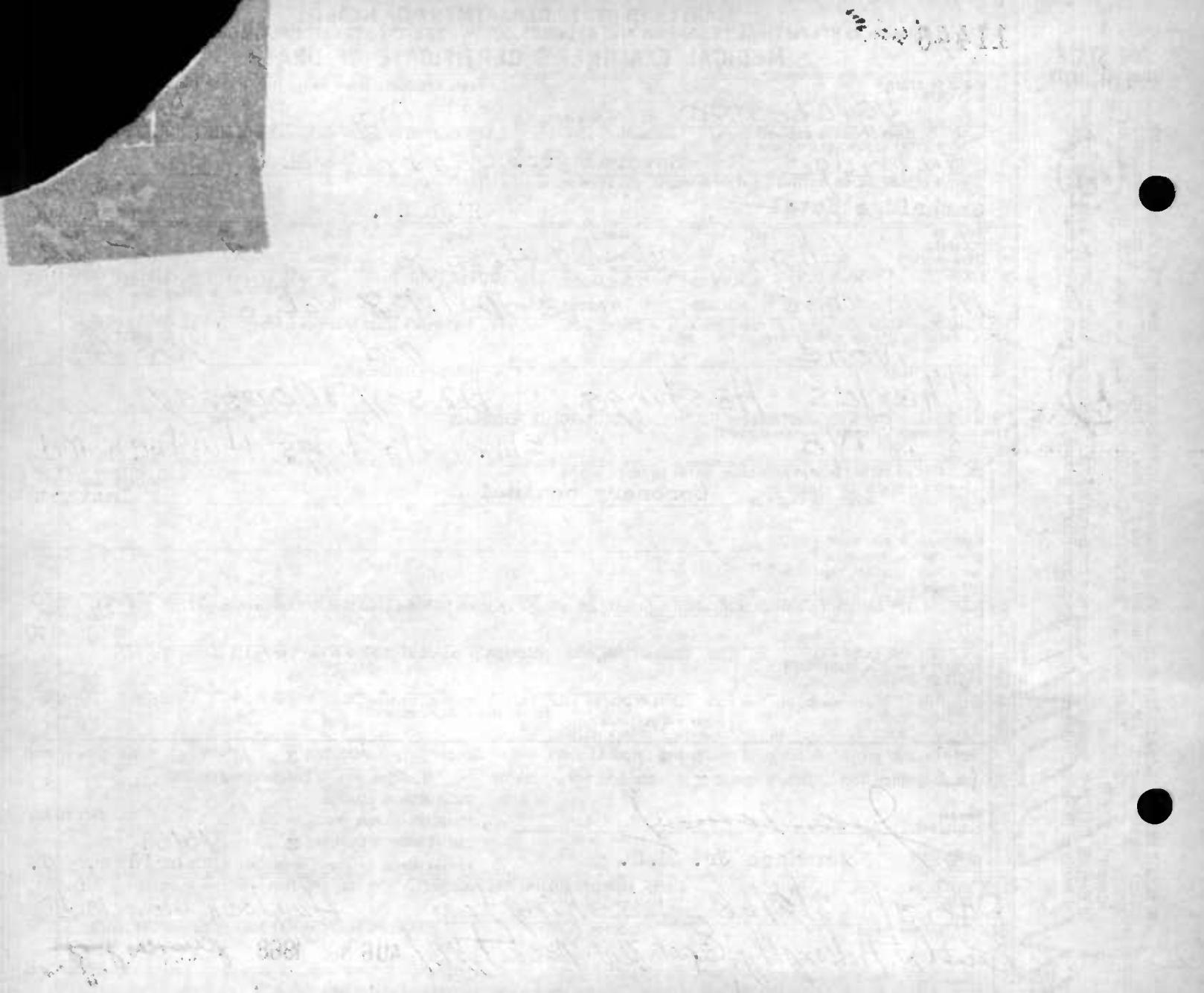
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

11448 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>	2. USUAL RESIDENCE (Where deceased lived, if institution; a. STATE <i>Md</i> b. COUNTY <i>Do.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	c. LENGTH OF STAY IN 1b <i>Several yrs</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cambridge Hotel</i>	d. STREET ADDRESS <i>High St.</i>						
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Charles Wesley Hastings</i>	4. DATE OF DEATH Month <i>8</i> Day <i>5</i> Year <i>1968</i>						
5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4/28/1908</i>	9. AGE (In years last birthday) <i>60 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Charles Hastings</i>	14. MOTHER'S MAIDEN NAME <i>Dorsey Mowbray</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>111-11-1111</i>	17. INFORMANT <i>Elmer Hastings, Hurlock, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Coronary occlusion</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4109 Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c)	DUE TO (b) DUE TO (c)	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 4201	20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Washington</i>	20f. (City or town) <i>Hurlock</i> (County) <i>Do.</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <i>John Mace Jr. M.D.</i>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22. DATE SIGNED <i>8/6/68</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8/8/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington</i>	23d. LOCATION (City, town or county) (State) <i>Hurlock Dor. Md</i>				
24. FUNERAL DIRECTOR <i>John S. Mellohly, East New Market, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>Charles George</i>	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>				
VR A1SME (5) 5M 1/65	DATE AUG 8 1968						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11455

1144				2a. DATE OF DEATH Month Aug. 11 Day 1968				2b. HOUR 12:30 A.M.			
1. DECEASED NAME (Type or print)		First ALONZA	Middle G.	Last HILL	2a. DATE OF DEATH						
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 10, 1890		6. AGE (In years lost birthday) 77		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer-Carpenter							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD # 3		12b. KIND OF BUSINESS OR INDUSTRY retired	
14. FATHER'S NAME John		First	Middle	Last	15. MOTHER'S MAIDEN NAME Amanda		First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. - - -		17. INFORMANT LeCompte Funeral Service records						Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1520 BLOOD LOSS SHOCK										1 HOUR	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1520 BLEEDING CARCINOMA OF DUODENUM										1-2 HOUR	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (1) this hospital attended the deceased from 8-10, 1968, to 8-14, 1968, that (2) (we) lost saw the deceased alive on 8-14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James F. McCarter		22c. DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-13-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 704 Locust Street Cambridge, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 13, 1968		23c. NAME OF CEMETERY OR CEMETARY Spalding-Seward Cemetery		23d. LOCATION (City or Town) Cambridge, RFD 3, Maryland		(County) (State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ONE OF THE

WORST POLITICAL MISTAKES

MADE BY THE FEDERAL GOVERNMENT SINCE THE DEPRESSION

FOR STATE
HEALTH DEPT.

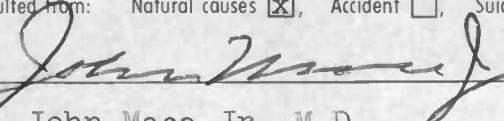
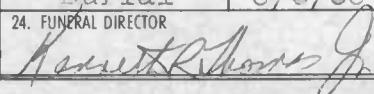
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 2 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11448

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11456

1. DECEASED-NAME (Type or Print)			First Ida	Middle Meta	Last Hoge	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month August	Day 4	Year 1968	2b. HOUR 7A M	
3. SEX Female	4. RACE White	S. DATE OF BIRTH June 15, 1886	6. AGE (in years last birthday) 82	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Doy Year 19	2d. HOUR M				
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge- Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13c. CITY OR TOWN Dorchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 411 E. Appleby Ave.			
14. FATHER'S NAME First Frank			Middle Fleischman	Last Matilda				Last Keene			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Earl Hoge			ADDRESS Somerset Ave. Cambridge Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Mins.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> John Mace Jr. M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Mace Jr. M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 8/6/68			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park			23d. LOCATION (City or Town) (County) (State) Cambridge Dorchester Md.		
24. FUNERAL DIRECTOR 			ADDRESS Cambridge Md.			25a. REC'D BY REGISTRAR DATE AUG 9 1968			25b. REGISTRAR'S SIGNATURE 		
VR A15ME (5) 10M REV. 1/68											

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in ~~part~~ in item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3.

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11442

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11457

1. DECEASED-NAME (Type or Print)			First MITCHELL	Middle W.	Lost HORWATH	20. DATE KNOWN OF ESTI. DEATH MATED	Month Aug	Day 30	Year 1968	21. HOUR 8:25 P.M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 4, 1893	6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN 0	2c. DATE PRONOUNCED DEAD Month 8	Day 30	Year 1968	24. HOUR 8:00 P.M.		
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		9. COUNTY OF DEATH Dorchester							
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer-Waterman			12b. KIND OF BUSINESS OR INDUSTRY Retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNT Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 617 Race Street					
14. FATHER'S NAME Michael			First ?	Middle Horwath	Lost	15. MOTHER'S MAIDEN NAME Marie			First ?	Middle Stettner	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 217-10-8887 xxx			16c. INFORMANT LeCompte Funeral Service records			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few mins.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>887X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 9035													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR AM 8 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 8/30/68 Fell in alley.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Alley			21f. LOCATION Street or R.F.D. No. Dunns Alley			City or Town Cambridge, Md.	County Dor. Co.	State Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 2, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park			23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland			22b. DATE SIGNED 9/2/68			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS			25a. REC'D BY REGISTRAR DA SEP 5 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

60 02 1982

1000

000000

000000

Refugees

1000

000000

Chernobyl

Evacuation

000000

Evacuee (s)

Refugee (s)

000000

Refugee (s)

000000

000000

Refugee (s) Evacuee (s) 000000

Refugee (s) Evacuee (s) 000000

Refugee (s) Evacuee (s) 000000

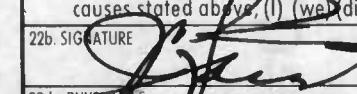
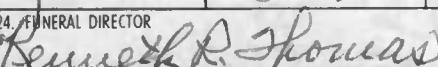
11450

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First William	Middle Carl	Last Humphreys	2a. DATE OF DEATH Month Aug. 7	Year 1968	2b. HOUR 8 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 2, 1892			6. AGE (In years last birthday) 76	IF UNDER 1 YEAR MONTHS YRS.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester			12b. KIND OF BUSINESS OR INDUSTRY Carpenter self-employed
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Maryland Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter			13e. STREET AND NUMBER R.F.D. 1	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER R.F.D. 1		
14. FATHER'S NAME William	First J.	Middle Humphreys	15. MOTHER'S MAIDEN NAME Amanda	Middle Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-18-2110	17. INFORMANT A. Mrs. Marian M. Humphreys, R.D.	Address Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic H.D. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200						
19a. DATE OF OPERATION 4200		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from May 6, 1968, to Aug. 7, 1968, that (I) (we) last saw the deceased alive on Aug. 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Aug. 9, '68	
22d. PHYSICIAN'S NAME (Type) EDWIN FASSETT, M.D.		22e. ADDRESS 623 HIGH STREET, CAMB., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 10, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial		23d. LOCATION (City or Town) Park, Cambridge, Md.	(County) (State) Dor
24. FUNERAL DIRECTOR 		ADDRESS Cambridge, Md.		25a. REC'D. BY REGISTRAR DATE AUG 14 1968	25b. REGISTRAR'S SIGNATURE 	

Johnson in November

circumstances

FOR STATE
HEALTH DEPT.

M
M
M

any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page
5 may be retained for your files.

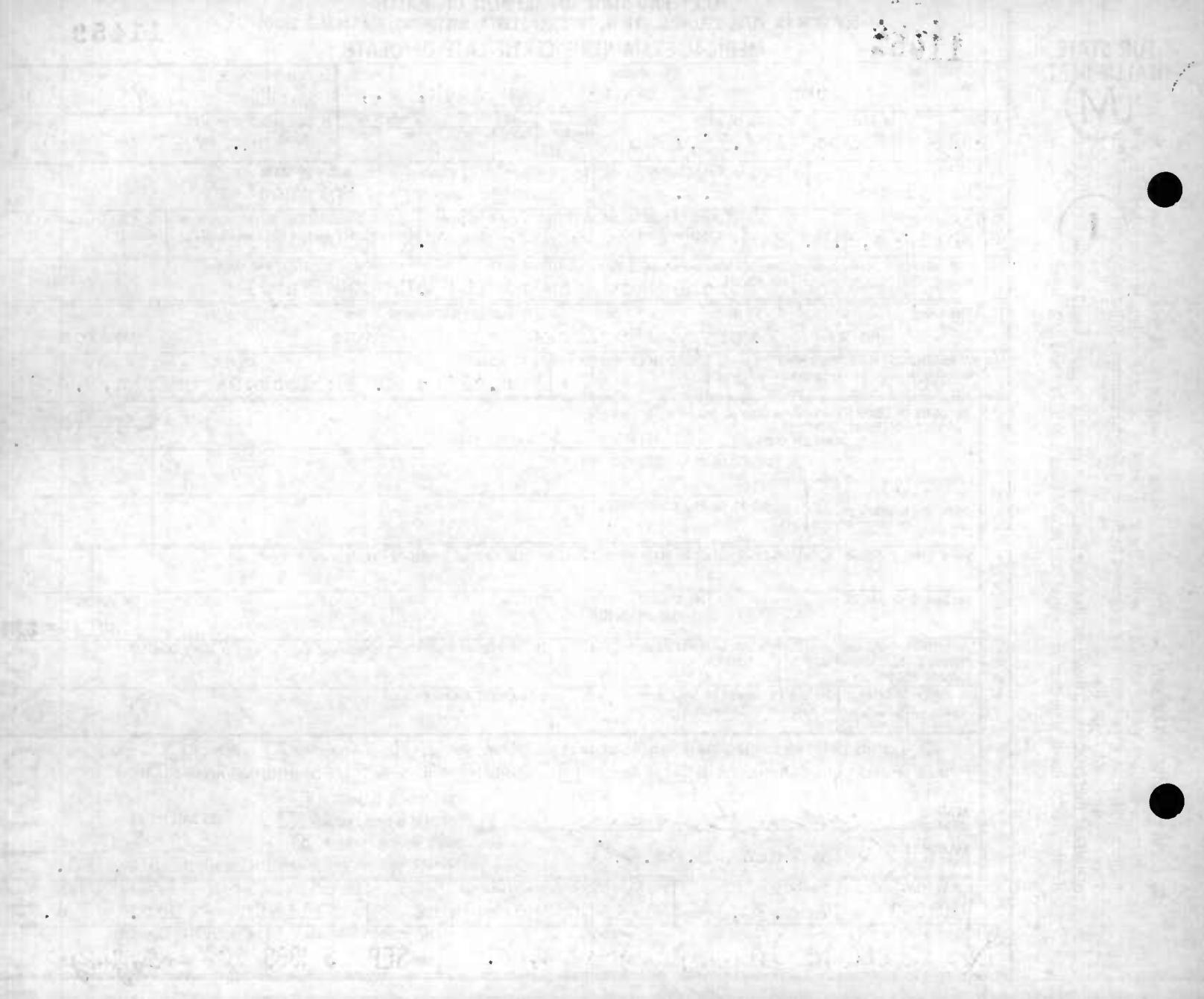
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11459

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First John	Middle Emory	Lost Hurllock, Jr.,	2a. DATE KNOWN OF ESTI- DEATH MATED	Month 8/27	Day 19	Year 68	P.M. 8P M
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2b. HOUR		
Male	White	Aug. 19, 1906			Hours	2d. HOUR		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH		
Maryland		U.S.				Dorchester		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge, R.D. 2		Enroute to Camb.		House Painter				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland		Dorchester		Cambridge	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	Rural	
14. FATHER'S NAME		First John	Middle Emory	Lost Hurllock	15. MOTHER'S MAIDEN NAME	First Anna	Middle	Lost Shenton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
NO				Mrs. Alice E. Hurllock, Cambridge, R.D. 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. BETWEEN ONSET AND DEATH 4109 30 Mins. (b) (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Mace Jr. M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 30, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Elliott Churchyard		23d. LOCATION (City or Town) Elliott		(County) Dor.	(State) Md.
24. FUNERAL DIRECTOR		ADDRESS Kenneth R. Thomas Cambridge, Md.		25a. REC'D BY REGISTRAR DATE SEP 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15ME 15 10M REV. 1/68								

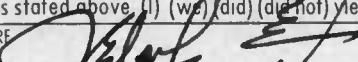


MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11460

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	2b. HOUR	
THOMAS JAMES JOHNSON						Month Day Year	2b. HOUR	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.
MALE		NEGROID	OCT. 24, 1888			79		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND		USA				DORCHESTER		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CAMBRIDGE		CAMBRIDGE MD. HOSP., INC.			LABORER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
MARYLAND		DORCHESTER	CAMBRIDGE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	602 EDGEWOOD AVENUE			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
GEORGE		W.	JOHNSON		ELLA			JAMES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		212-12-5662		VATICE COLDER		516 PINE STREET 21613		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>								
4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
4221								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22o. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1967</u> , to <u>Aug. 4, 1968</u> , that (I) (we) los saw the deceased alive on <u>Aug. 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE 								
22c. DATE SIGNED <u>Aug. 5, 1968</u>								
22d. PHYSICIAN'S NAME (Type)		J. EDWIN FASSETT, M.D.		DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	
22e. ADDRESS <u>623 HIGH STREET, CAMBRIDGE, MARYLAND</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8/7/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>BETHEL</u>			23d. LOCATION (City or Town) <u>CAMBRIDGE</u> (County) <u>DOR. MD.</u> (State)	
24. FUNERAL DIRECTOR		ADDRESS <u>CAMBRIDGE, MD.</u>			25a. REC'D BY REGISTRAR DATE <u>AUG 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

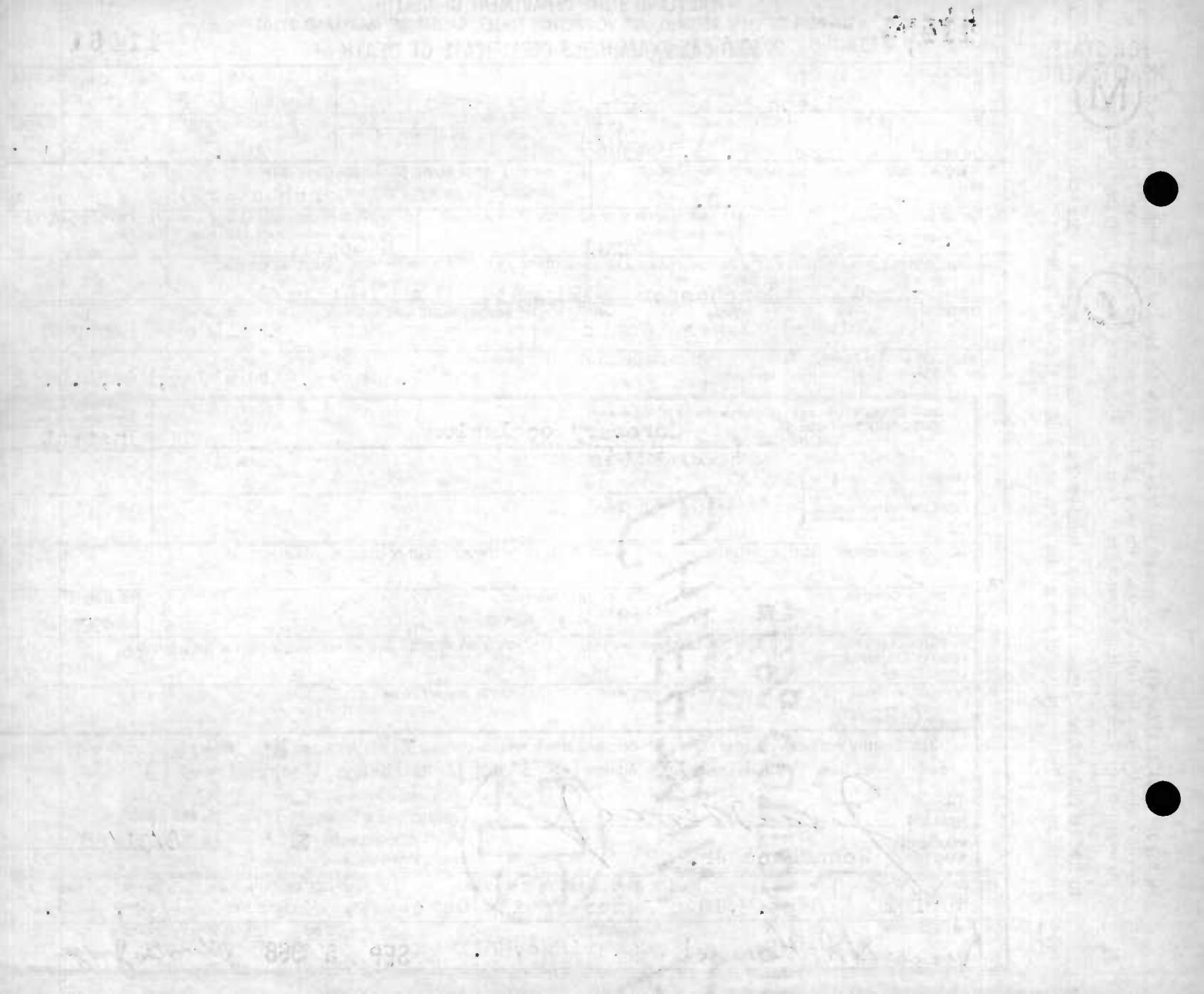
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ~~funeral~~ director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH 11453 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 2a, FilmGL04 9/MEDICAL EXAMINER'S CERTIFICATE OF DEATH												11461		
1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN Month Day Year			2b. HOUR					
Wilson			Levin	Jones		18	30	1968	M					
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PROOUNCED DEAD Month Day Year			2d. HOUR					
Male	White	Feb. 21, 1903	65 YRS			Aug.	30	1968	8 P.M.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland		U.S.				Dorchester								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Wingate			Rural			Laborer								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Dorchester			Wingate			Rural					
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Edward			James	Jones		Mary			Emaline	Fitzhugh				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
(If yes give war or dates of service)						Herbert E. Jones, Cambridge, Md., R.D. 2								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion												Instant		
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John Mace Jr.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE Sept. 2, 1968 23c. NAME OF CEMETERY OR CREMATORIAL Jones Family Cemetery, Wingate												22b. DATE SIGNED 8/31/68		
23d. LOCATION (City or Town) (County) (State) Dor. Md.												ADDRESS (Street, city, town, or county)		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Kenneth A. Thomas			Cambridge, Md.			DATE SEP 5 1968			Charles Judge					



FOR STATE
HEALTH DEPT.

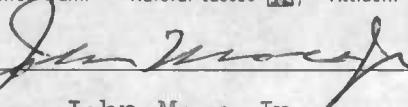
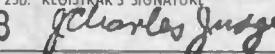
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

11454 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11462

1. DECEASED-NAME (Type or Print)	First GOLDA	Middle WILLEY	Last LAWSON	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month Aug.	Day 31	Year 1968	24. HOUR P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Oct. 31, 1897	6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	24. HOUR P.M.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13c. CITY OR TOWN Dorchester	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER RFD No. 2, Drawbridge					
14. FATHER'S NAME Daniel J. Willey	15. MOTHER'S MAIDEN NAME Alberta			Middle Hughes	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. - - -	16c. INFORMANT unk	ADDRESS LeCompte Funeral Service records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). } stating the underlying cause } last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Fracture neck right femur								
19a. DATE OF OPERATION 12/15/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture neck r. femur			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year 10 AM 11/30/1967	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Slipped and fell on ice.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f. LOCATION Street or R.F.D. No. R.F.D. 2	City or Town Cambridge	County Dor.	State Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 	CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) John Mace Jr.	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22b. DATE SIGNED 9/2/68								
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept 3 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	23d. LOCATION (City or Town) Cambridge, Maryland	(County)	(State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 5 1968	25b. REGISTRAR'S SIGNATURE 					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1146.3

CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Arthur</i>	Middle <i></i>	Last <i>Madday</i>	2a. DATE OF DEATH Month <i>8</i>	Day <i>2</i>	Year <i>1968</i>	2b. HOUR <i>3 PM</i>	
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>01-19-68</i>			6. AGE (In years lost birthday) <i>80</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. DAYS <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Dorchester</i>					
10. CITY OR TOWN OF DEATH <i>Rural-Pemberton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Somerset</i>	13c. CITY OR TOWN <i>Fairmount</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER				
14. FATHER'S NAME First <i>Robert</i>	Middle <i></i>	Last <i>Madday</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Margaret Madday</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Med. Records</i>	Address <i>Eastern Shore State Hospital</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4369</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>ARTERIOSCLEROSIS GENERAL AND CEREBRAL</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>331X</i>								
19a. DATE OF OPERATION <i>3/31/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory. OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>9-18-68</i> , to <i>8-2-68</i> , that <input type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>9-2-68</i> , and that in <input type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <i>Miguel A. de la Guardia, M.D.</i>		22c. DATE SIGNED <i>8/2/68</i>	22d. PHYSICIAN'S NAME (Type) <i>MIGUEL A. de la GUARDIA, M.D.</i>	22e. ADDRESS <i>E.S.S.H.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>8/6/68</i>	23c. NAME OF CEMETERY OR CEMETARY <i>Centenario</i>	23d. LOCATION (City or Town) <i>Fairmount, Maryland</i>	(County) <i></i>	(State) <i></i>			
24. FUNERAL DIRECTOR <i>William J. Deas Jr.</i>	ADDRESS <i>1100 W. 36th Street</i>	25a. REC'D BY REGISTRAR <i>Aug 8 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>					

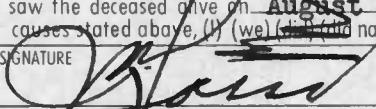
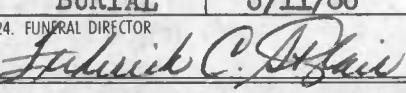
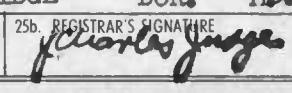
1001

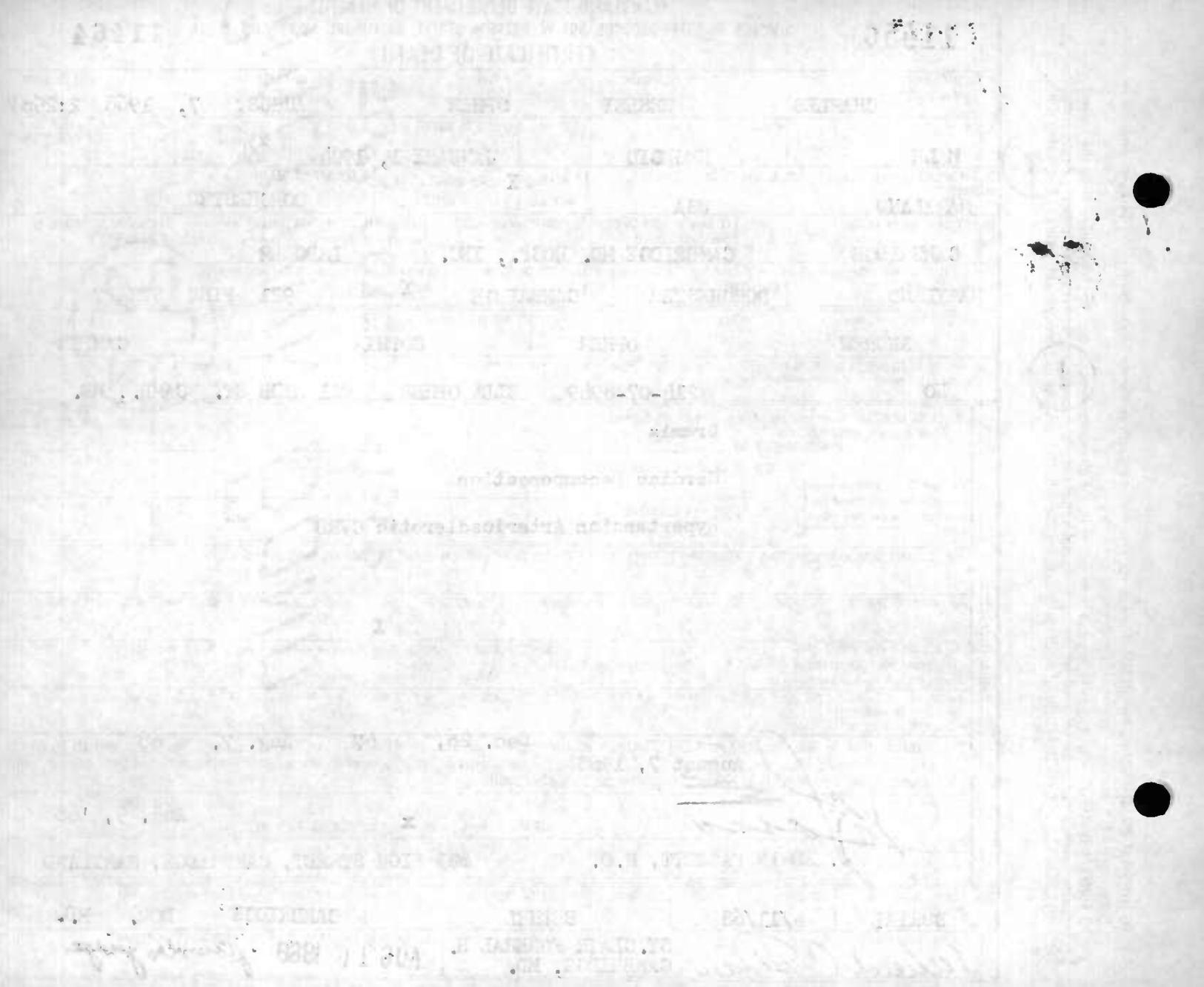
8801

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First CHARLES	Middle WESLEY	Last OPHER	2a. DATE OF DEATH Month AUGUST	Day 7	Year 1968	2b. HOUR 2:25 p.m.		
3. SEX MALE	4. RACE NEGROID	5. DATE OF BIRTH JANUARY 1, 1904		6. AGE (In years last birthday) 64	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER						
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MD. HOSP. INC.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY CAMPER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 921 PINE STREET					
14. FATHER'S NAME ANDREW	First OPHER	Last SOPHIA	15. MOTHER'S MAIDEN NAME First CAMPER		Middle 921 HIGH ST. CAMB., MD.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-07-8949	17. INFORMANT ELLA OPHER	Address 921 HIGH ST. CAMB., MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia									
4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Cardiac Decompensation									
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Arteriosclerotic CVRD									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 442X									
19a. DATE OF OPERATION 442X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1967 , to Aug. 7, 1968 , that (I) (we) last saw the deceased alive on August 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (we) did not view the body after death.							22c. DATE SIGNED Aug. 9, '68		
22b. SIGNATURE 	22c. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (Type) EDWIN FASSETT, M.D.	22e. ADDRESS 921 HIGH STREET, CAMBRIDGE, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/11/68	23c. NAME OF CEMETERY OR CREMATORIAL BETHEL	23d. LOCATION (City or Town) CAMBRIDGE		(County) DOR.	(State) M.D.			
24. FUNERAL DIRECTOR 	25a. ADDRESS ST. CLAIR FUNERAL H. CAMBRIDGE, MD.		25b. REC'D BY REGISTRAR DATE AUG 16 1968	25b. REGISTRAR'S SIGNATURE 					



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11465

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR			
			FRRed	E.	Prettyman	OF ESTI- MATED <input type="checkbox"/> 8-7 1968 3:15						
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF HRS.	MIN.	2c. DATE PRONOUNCED DEAD Month 8 Day 7 Year 1968 3:45 2d. HOUR PM				
Male	White	6/17/1899	09 YRS.									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH						
Delaware		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dorchester						
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farm.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13c. CITY OR TOWN Dor.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 203 Hayward St.			
14. FATHER'S NAME Edward			15. MOTHER'S MAIDEN NAME Prettymen			Lou			Roach			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-54-5520			17. INFORMANT Mrs. Pearl McDowell, Cambridge, Md.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Mins.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											22b. DATE SIGNED 8/10/68	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Mace Jr. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county) Cambridge, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/10/68		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery			23d. LOCATION (City or Town) Laurel		(County)	(State)		
24. FUNERAL DIRECTOR		ADDRESS Windsor & Disharoon Laurel, Del.			25a. REC'D BY REGISTRAR DATE AUG 14 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11466

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11458		First <i>ISAAC</i>	Middle <i>A</i>	Last <i>Queen</i>	2a. DATE OF DEATH Month <i>8</i> Day <i>4</i> Year <i>1968</i>	2b. HOUR <i>8:50 AM</i>
1. DECEASED-NAME (Type or print)	3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>8-12-85</i>	6. AGE (In years last birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>4</i> HOURS <i>8</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Dechester</i>			
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>E.S.S. H.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Waiter</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>Oxford</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Box 355</i>		
14. FATHER'S NAME First <i>John</i>	Middle <i>Queen</i>	15. MOTHER'S MAIDEN NAME First <i>Priscilla</i>	Middle <i>Unknown</i>	Last <i>Unknown</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>212 07 371</i>	17. INFORMANT <i>Hytolia Bailey</i>	Address <i>Oxford, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>185X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>177X</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Adenocarcinoma of Prostate</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Blurred Effusion; Coronary Artery Disease; generalized cerebral arteriosclerosis</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>Day</i> <i>Year</i> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <i>5-18, 1967, to 8-4, 1968</i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8-3-68</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Donald A. Kellogg MD</i>	22c. DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED <i>8/4/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Donald A. Kellogg</i>	22e. ADDRESS <i>EASTERN SHORE STATE HOSPITAL</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Aug. 7, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Screamersville</i>	23d. LOCATION (City or Town) <i>Oxford</i> (County) <i>Talbot</i> (State) <i>Maryland</i>			
24. FUNERAL DIRECTOR <i>B.E. Darrell</i>	ADDRESS <i>426 Dover Rd</i>	25a. REC'D BY REGISTRAR <i>Easton</i>	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>	DATE <i>AUG 7 1968</i>		

卷之三

卷之三

10

1920-1921

3

2000

1000

35725.33 6

10

220

1886-1887

1920-1921

10

1960-1961. (Continued from page 111)

Polynya's with depth 1000 m

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of a death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11459 11407

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b Vienna		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Vienna	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glasgow Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Komma		First Ann	Middle Reid
4. DATE OF DEATH 8/15		Month 19	Day 68
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/29/1882		9. AGE (in years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 5 Days 10 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Minos Lewis Henry		14. MOTHER'S MAIDEN NAME Martha Ann Le Compte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest		19. INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease		DUE TO ?	
DUE TO ?		(c) ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cambridge, Md.
20f. (City or town) Cambridge (County) Md. (State) Md.		21. I certify that (I) (this hospital) attended the deceased from 11-7 , 19 67 , to 8-15 , 19 68 , that (I) (we) last saw the deceased alive on 8-12 , 19 68 , and that death occurred at 2 A M , from the causes and on the date stated above.	
22a. SIGNATURE Richard G. Bledsoe		22b. DATE SIGNED 8-15-68	
22c. PHYSICIAN'S NAME (Type) RICHARD G. BLEDSE		22d. ADDRESS Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park Cambridge, Md.
24. FUNERAL DIRECTOR Herbert Thomas Jr. Cambridge, Md.		25a. ADDRESS Cambridge, Md.	
25b. REC'D BY REGISTRAR Charles J. Charles		25c. REGISTRAR'S SIGNATURE Charles J. Charles	

3460-2000

5

small prairie wolf (?)

— 18 —

2668

2000-01-02

01 2 32 5781.25/E

W. J. H.

Document released under the Access to Information Act

27:14 ~~and~~ 28:14

std::map<std::string, std::string> m;

Yannick received a copy of

The main results

Jan. 10, 1960 C. S. C.

ANSWER BOOK STRUCTURE

Line 2

20 21-22 50 50

2.3. $\Delta_1 = 0$

33

methods a. heated

• 114 • 第二部分

中華書局影印

W. Glindon R. with others

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper, pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11468

CERTIFICATE OF DEATH

11469

1. PLACE OF DEATH a. COUNTY DORCHESTER COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE M.D.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMBRIDGE MD		c. LENGTH OF STAY IN 1b 1 yr 11 mo	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WYE MILLS		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glasgow Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) SARAH B. BODIE	First	Middle	Last	4. DATE OF DEATH ROE	Month 8	Day 5	Year 1968				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/74	9. AGE (in years last birthday) 94 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE		10b. KIND OF BUSINESS OR INDUSTRY RETIRING		11. BIRTHPLACE (County & State, or foreign country) QUEEN ANNE'S CO MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Emery Theodore Roe		14. MOTHER'S MAIDEN NAME MARY TEMPERANCE Covington		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-48-6066		17. INFORMANT Mrs. Ruth P. Roe, Wye Mills, Maryland		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction		10 minutes	
4109 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior-posterior Heart Disease		?	
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
--	--	---	--

4201		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from 11-17 , 19 67 , to 8-5 , 19 68 , that (I) (we) last saw the deceased alive on 8-5 , 19 68 , and that death occurred at 5 P.M. from the causes and on the date stated above.	
--	--

22a. SIGNATURE Richard G. Bildeau		22b. DATE SIGNED 8-5-68	
22c. PHYSICIAN'S NAME (Type) RICHARD G. BILODEAU		22d. ADDRESS CAMBRIDGE, MD.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery, Centreville, Queen Anne's, Md.		23d. LOCATION (City, town or county) (State) Centreville, Queen Anne's, Md.	
24. FUNERAL DIRECTOR Smith & Barto, Jr. Barto Bros, Centreville, Md.		ADDRESS		25a. REC'D BY REGISTRAR AUG 9 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11470

11462

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH	2b. HOUR		
Allie Fair Smith							Month Day Year	11P M		
3. SEX		4. RACE		S. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		October 22, 1889		78 yrs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Md.		U.S.		Cambridge-Md. Hospital		Dorchester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		13a. USUAL RESIDENCE (Where deceased admission) STATE		
Cambridge		Cambridge-Md. Hospital				Homemaker		Md.		
13a. USUAL RESIDENCE (Where deceased admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		14. FATHER'S NAME		
Md.		Dorchester		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1309 Race St.		First Middle Last		
George		E. Willey		Dorothy				Shorter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No				Mr. Charlie P. Smith		Cambridge Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE										
4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X FAR ADVANCED PULMONARY TUBERCULOSIS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1967, to 8-26-68, 19, that (I) (we) last saw the deceased alive on 8-26-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		Albert E. Bunker, M. D.			DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8-28-68	
22d. PHYSICIAN'S NAME (Type)		Albert E. Bunker, M. D.			22e. ADDRESS 200 Md. Ave., Cambridge, Md. 21613					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Burial Aug. 29, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery		23d. LOCATION (City or Town) Cambridge Dorchester Md.		(County) (State)		
24. FUNERAL DIRECTOR		ADDRESS Cambridge Md. 21613				25a. REC'D BY REGISTRAR SEP 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

11463

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11471

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First LENA	Middle HARRIETT	Last TODD	2a. DATE OF DEATH Month August 4 Year 1968	2b. HOUR 11:10 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 25, 1898		6. AGE (In years last birthday) 70		IF UNDER 1 YEAR YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Hurlock		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bellevue Haven Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER R.F.D. (Near Harmony)	
14. FATHER'S NAME First Abijah Ivins		15. MOTHER'S MAIDEN NAME First Dora Carroll							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Alva W. Todd, Preston, Maryland, R.F.D.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Vaginostatic Cardiac Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201		DUE TO, OR AS A CONSEQUENCE OF Coronary Arteriosclerosis				10 yrs			
		DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis				15 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Removed Carcinoma of Rectum 10 yrs old right hemiplegia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY. OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 8/15/68, 19, to 8/4/68, 19, that (I) (we) last saw the deceased alive on 8/1/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE Harold B. Plummer M.D.		22c. DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		DATE SIGNED 8/8/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Preston Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 7, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		23d. LOCATION (City or Town) Federalsburg, Maryland		(County) (State)	
24. FUNERAL DIRECTOR J. J. Frampton		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (A) 30M REV. 1/66				DATE AUG 15 1968					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

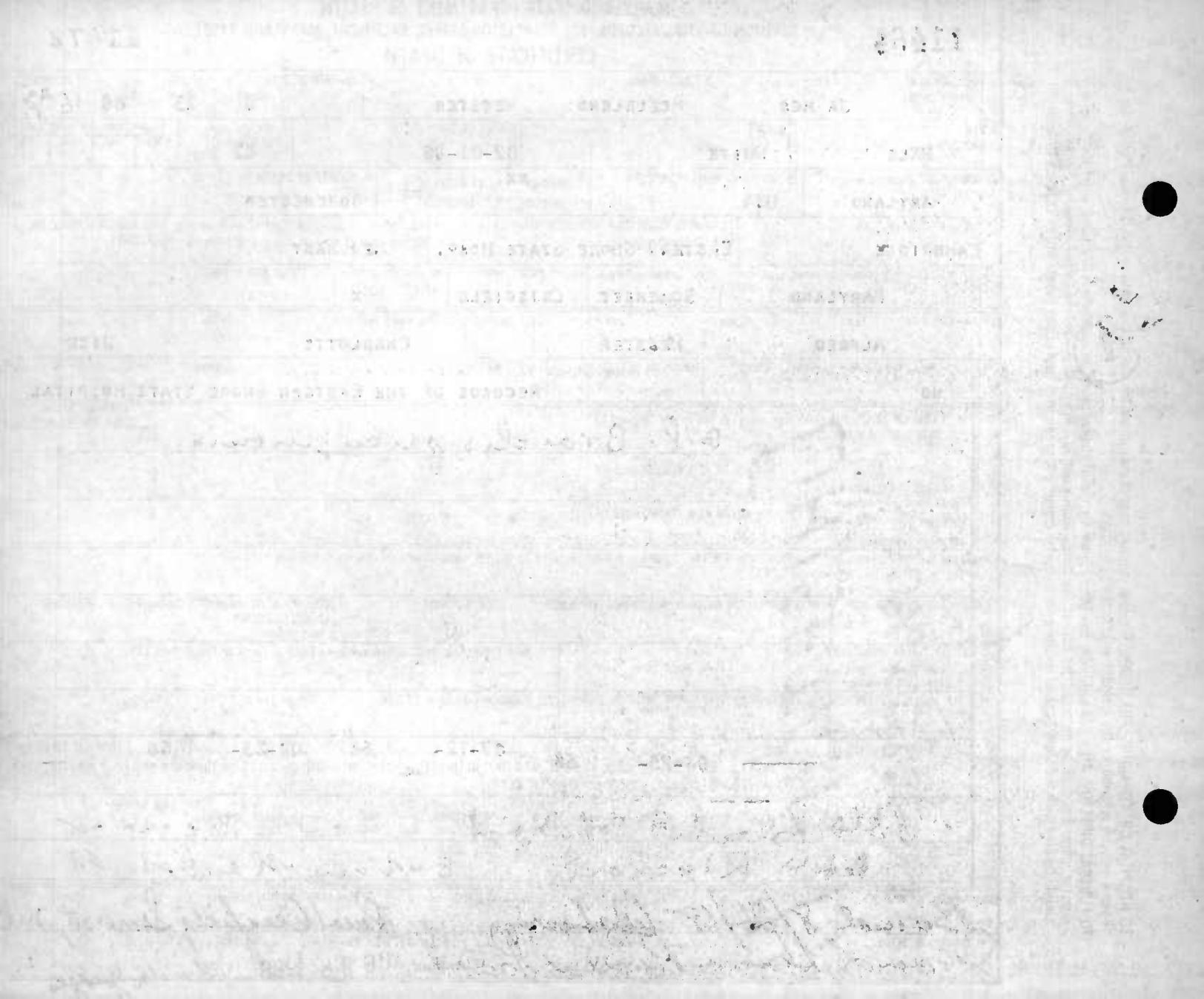
CERTIFICATE OF DEATH

11472

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First JA MES	Middle MCCLELAND	Lost WEBSTER	20. DATE OF DEATH Month 8	20. DATE OF DEATH Month 8	20. DATE OF DEATH Month 8	20. DATE OF DEATH Month 8	2b. HOUR 6:30 P.M.			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 02-01-86			6. AGE (In years lost birthday) 82 YRS.			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
7b. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH DORCHESTER								
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY SOMERSET	13c. CITY OR TOWN CRISFIELD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER							
14. FATHER'S NAME ALFRED	First WEBSTER	Middle WEBSTER	Lost	15. MOTHER'S MAIDEN NAME CHARLOTTE	First	Middle	Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			Address						
RECORDS OF THE EASTERN SHORE STATE HOSPITAL											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) B.P., Branches pulmonary											
485 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 491											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from 07-12-1968 to 08-23-1968 , that (I) (we) lost saw the deceased alive on 08-23-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Patricia Rieckert, Pollock	22c. ATTENDING DEGREE PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 8-24-68									
22d. PHYSICIAN'S NAME (Type) Patricia Rieckert	22e. ADDRESS E-New Market, MD										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/26/68	23c. NAME OF CEMETERY OR CREMATORIAL Leesburg	23d. LOCATION (City or Town) Leesburg, Somerset, Md			(County)		(State)			
24. FUNERAL DIRECTOR James L. Dennis Funeral Home	ADDRESS	25a. RECEIVED BY REGISTRAR Charles George			25b. REGISTRAR'S SIGNATURE			DATE AUG 28 1968			



CERTIFICATE OF DEATH

11473

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First SAMUEL	Middle PERCY	Last WHEATLEY	2a. DATE OF DEATH Month August	Day 14	Year 1968	2b. HOUR 4:45								
3. SEX Male		4. RACE White	5. DATE OF BIRTH October 6, 1909			6. AGE (In years last birthday) 58		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0		IF UNDER 12 HRS. HOURS 0		MIN 0			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester		Md.									
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Maryland Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic and Electric Welder			12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Taylor Avenue									
14. FATHER'S NAME First Samuel W. Wheatley		Middle	Last	15. MOTHER'S MAIDEN NAME First Nettie Medford		Middle	Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WW II 220-01-7289		17. INFORMANT Mrs. Anna N. Wheatley, Hurlock, Maryland		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION								TERMINAL							
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS								1st YES							
(b)		DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS								2nd YES							
(c)		GENERALIZED ARTERIOSCLEROSIS															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
4201 MEDICAL CERTIFICATION		DIABETES MELLITUS		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (I) (This hospital) attended the deceased from Aug 12, 1968 , to Aug. 19, 1968 , that (I) (we) last saw the deceased alive on Aug 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Donald R. McWilliams</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8-20-68											
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams, M. D.		22e. ADDRESS P. O. Box 248, East New Market, Maryland															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 16, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Eldorado Cemetery		23d. LOCATION (City or Town) Eldorado, Maryland		(County)		(State)							
24. FUNERAL DIRECTOR <i>from Frampton Jr.</i>		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge											

2021

but you can't see the world in the same way

you can't see the world in the same way

you can't see the world in the same way

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11466

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11474

1. DECEASED-NAME (Type or Print)			First CLARENCE	Middle O.	Lost WILCOX	2a. DATE KNOWN OR ESTI- MATED	Month Aug 26	Day 1968	Year M	2b. HOUR M	
3 SEX Male	4. RACE White	S. DATE OF BIRTH June 13, 1879	6. AGE (In years last birthday) 89	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 19			2d. HOUR M		
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			12b. KIND OF BUSINESS OR INDUSTRY Seafood		
10. CITY OR TOWN OF DEATH RFD 3, Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Casons Neck, RFD 3			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waitman			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN RFD 3 Cambridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Casons Neck, RFD 3		
14. FATHER'S NAME Stephen			First O.	Middle Wilcox	Lost	15. MOTHER'S MAIDEN NAME Mary			Middle ?	Lost Arnold	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-34-8433A			17. INFORMANT LeCompte Funeral Service records			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Mins.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.	22b. DATE SIGNED 8/27/68
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial			23b. DATE Aug 29, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Spedden-Seward Cemetery			23d. LOCATION (City or Town) RFD 3, Cambridge, Maryland (County) (State)		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE AUG 30 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15ME (5) 10M REV. 1/68											

1000 JOURNAL OF CLIMATE

C. W. COLEMAN

ANSWER

6

ANSWER

8

Ecology.

四庫全書

6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11467		2a. DATE OF DEATH Month Day Year August 24 1968				2b. HOUR 6 15 A.M.			
1. DECEASED-NAME (Type or print)		First Gale	Middle Wade	Last Willey Jr	5. DATE OF BIRTH August 19, 1968		6. AGE (In years last birthday) YRS. 5		
3. SEX Male		4. RACE White		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital, Inc.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 300 Byrn Street			
14. FATHER'S NAME First Gale		Middle Wade	Last Willey	15. MOTHER'S MAIDEN NAME Barbara Ann Todd		Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Toddville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		774.9 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.		Reinictus DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH +8 days Pneumonitis, 6 mo Gestation 10 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		770.6		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
19a. DATE OF OPERATION 770.6		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. LOCATION Street or R.F.D. No. City or Town County State			
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-26-68			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>August 14, 1968</u> , to <u>August 24 1968</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>August 23 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) (did not) view the body after death.		22b. SIGNATURE Donald Mc Williams		22e. ADDRESS East New Market, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE August 26, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Family Plot		23d. LOCATION (City or Town) Toddsville		(County) (State) Dorchester Md			
24. FUNERAL DIRECTOR LeCompte Funeral Service		ADDRESS 308 High Street Cambridge, Md.		25a. REC'D BY REGISTRAR DATE SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

2011

000 01928

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11468

11476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First HOWARD	Middle TilDON	Lost Willey	2a. DATE OF DEATH Month Aug.	Day 4	Year 1968	2b. HOUR 3:30 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 03-24-75		6. AGE (In years last birthday) 93	7. IF UNDRL 1 YEAR MONTHS	8. IF UNDER 24 HRS. DAYS	9. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S. A.	8. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORchester			
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY DOR.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER 1207 RACE ST.				
14. FATHER'S NAME James	First Middle Willey	15. MOTHER'S MAIDEN NAME Dorothy	16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or UNKNOWN (If yes give war or dates of service)				Address Cambridge	
17. INFORMANT MRS. J. SPEDDEN (daughter)				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Speed</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>4339</u> (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis.</u>				
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Occlusion of femoral artery; Coronary artery disease; Pneumonia</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY. OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7-26</u> , 19 <u>68</u> , to <u>8-4</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8-4</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <u>Donald G. (Cecil) Goff</u>	22c. DATE SIGNED <u>8/4/68</u>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) <u>Donald G. (Cecil) Goff</u>	22e. ADDRESS EASTERN SHORE STATE HOSP.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 6, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Bucktown Churchyard	23d. LOCATION (City or Town) Cambridge	(County) Md.	(State) R.D.			
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas Jr.</u>	ADDRESS Cambridge Md.	25a. REC'D BY REGISTRAR DATE AUG 9 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Ralph</i>	Middle <i>Williams</i>	Lost <i>Williams</i>	2a. DATE OF DEATH Month <i>8</i>	Day <i>28</i>	Year <i>68</i>	2b. HOUR <i>2 PM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>08-19-03</i>		6. AGE (In years lost birthday) <i>65</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	IF UNDER 24 HRS. MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Dorchester</i>						
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>E.S.S.H.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>W.C.</i>	13c. CITY OR TOWN <i>Salisbury</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>513 Waries St.</i>					
14. FATHER'S NAME First <i>William</i>	Middle <i>August</i>	Lost <i>Williams</i>	15. MOTHER'S MAIDEN NAME First <i>Gertrude</i>	Middle <i>Jasmine</i>	Last <i>Jasmine</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes, no, or unknown</i>	16b. SOCIAL SECURITY NO. <i>(If give war or dates of service)</i>	17. INFORMANT <i>E.S.S. Hosp. Records - Cambridge</i>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129</i> Bronchitis pneumonitis DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic congestive heart failure</i> a month DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized atherosclerosis with other atherosclerotic undeter- mined</i> heart disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>Diabetes mellitus, chronic lung disease.</i>							heart disease		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>8/22/68</i> , to <i>8/28/68</i> , 1968, that (I) (we) last saw the deceased alive on <i>8/28/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED <i>8/28/68</i>		
22b. SIGNATURE <i>Faruk Ozer</i>	DEGREE ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (Type) <i>FARUK OZER</i>	22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-9-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore, Md</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>				
24. FUNERAL DIRECTOR <i>Booker M. West</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>SEP 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11470		HENRY						WILMER				8 Month 11 Day 68 Year		11:55 P.M.	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR								
HENRY		Dudley		Wilmer	8-12-68		11:55 P.M.								
B. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		Negro		8-12-98		690 YRS.		MONTHS		DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Dorchester							
MD.		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
CAMBRIDGE		EASTERN SHORE STATE HOSP.		FARMER											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER									
MD.		TALBOT		YES <input type="checkbox"/>		Rt. # 1									
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last						
		John		Wilmer			Rosa		WARNER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		218 24 5696		Bertha Wilson		Cordova, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) 4369 Cerebral Vascular Accident.															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X Generalized Arteriosclerosis															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)															
Pulmonary Hypertension, Thromboembolism, Chronic Pyelonephritis															
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 7-15		City or Town 19-68		County		State					
22a. I certify that (I) (This hospital) attended the deceased from 8-11 1968, to 8-11 1968, that (I) (we) last saw the deceased alive on 8-11 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.															
22b. SIGNATURE Donald A. Kenog		22c. DEGREE DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED 8/11/68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		EASTERN SHORE STATE HOSPITAL											
DONALD A. KENOG															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/13/68		23c. NAME OF CEMETERY OR CREMATORIUM Newtown		23d. LOCATION (City or Town) Cordova		(County) Talbot		(State) Maryland					
24. FUNERAL DIRECTOR P.S. J. Dashiell		ADDRESS 426 Dover Easton Md		25a. REC'D BY REGISTRAR DATE AUG 16 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge									

FOR STATE
HEALTH DERT.

11471
M

Any delay is
in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

11479
D

11471
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First WILLIS	Middle C.	Lost WINDSOR, Jr.	2a. DATE KNOWN OF ESTI- DEATH MATED	Month 8	Day 12	Year 1968	2b. HOUR 9:30 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 8, 1960	6. AGE (in years last birthday) 8 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month 8 Day 12 Year 1968			2d. HOUR 9:30 PM
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH Dorchester						
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Spring Drive, RFD #2					
14. FATHER'S NAME First Willis	Middle C.	Lost Windsor	15. MOTHER'S MAIDEN NAME First Louise	Middle ?	Lost Spear				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT LeCompte Funeral Service records	ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries, severe</u> DUE TO, OR AS A CONSEQUENCE OF 8147 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 2124									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:27 PM 8/12/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hit by car on Highway.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. City or Town US 50 Near Cambridge, Dor.		County Md.	County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 15, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	23d. LOCATION (City or Town) Cambridge, Maryland		(County) (State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS			25a. REC'D BY REGISTRAR DATE AUG 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME (4) 10M REV. 1/68									

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11480

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First WILLIAM	Middle JAMES	Last WRIGHT	2a. DATE OF DEATH Month August 12 1968	2b. HOUR P.M.
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH January 19, 1918		6. AGE (In years last birthday) 50	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN. Md.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED Separated WIDOWED DIVORCED	9. COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Maryland Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Day Laborer - Canning Factory	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md. Maryland	13b. CITY OR TOWN Dorchester	13c. CITY OR TOWN Hurlock	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. #2, Box 26	
14. FATHER'S NAME First Willie Wright	Middle	Last	15. MOTHER'S MAIDEN NAME First Minnie Strawberry	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No	16b. SOCIAL SECURITY NO. 220-01-8168	17. INFORMANT Mrs. Edna Wright, Hurlock, Md., RFD #2	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonitis, right lower lobe</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2509 7 days					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u>					
(b) <u>Nephritis</u> Undet.					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Diabetes Mellitus</u> Undet.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) Alcoholism.					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) the hospital attended the deceased from 8/10/68, 19, to 8/12/68, 19, that (I) we last saw the deceased alive on 8/12/68, 19, and that in (my) we opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alfred R. Maryanov</u>			DEGREE ATTENDING PHYS.	MED. DIRECTOR, <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8/19/68
22d. PHYSICIAN'S NAME (Type) <u>Alfred R. Maryanov, M. D.</u>			22e. ADDRESS 610 Race St., Cambridge, Maryland 21613		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 17, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Washington Cemetery	23d. LOCATION (City or Town) Hurlock, Maryland	(County)	(State)
24. FUNERAL DIRECTOR J. J. Frampson and Son, Federalsburg, Maryland	ADDRESS Federalsburg, Maryland	25a. REC'D. BY REGISTRAR AUG 22 1968	25b. REGISTRAR'S SIGNATURE <u>James J. Frampson</u>		

